

CRISIS STABILIZATION FUNDING REQUEST

District _____ I _____ II

Provider Requesting Funding: _____

Consumer's Name: _____ Consumer Age: _____

- ☐ Life, Safety, or Welfare Concern For the Consumer and/or his/her Family
- ☐ Critical circumstances (is on DDSN Critical waiting list)

Description of Circumstances (District will access plan via CAP, and services notes from the notes module, so include any additional information here):

Resources Available if Consumer/Parent-Legal Guardian of Minor:

Type/Amount of Service/Support Requested:

Estimated Cost of Service/Support Requested: \$ _____

Provider Executive Director/CEO Signature

Date

****FOR DISTRICT USE ONLY****

☐ Approved ☐ Partially Approved* ☐ Denied

Funding Approved: \$ _____

Description of how funding will be/is anticipated to be used:

*Explain: _____

District Office Director or Designee

Date

cc: Provider